9/24/77 [2]

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THE PRESIDENT'S SCHEDULE

Saturday - September 24, 1977

9:00 Dr. Zbigniew Brzezinski - The Oval Office.

1:00 Depart South Grounds via Helicopter
en route Andrews AFB, Roanoke, Norfolk,
and Williamsburg, Virginia.

9:00 Return to the South Grounds via Helicopter.

9:20 Depart South Grounds via Motorcade en route
Washington Hilton Hotel.

9:30 Drop-By Congressional Black Caucus Dinner.

10:00 Return to the South Grounds.

THE WHITE HOUSE
WASHINGTON

September 24, 1977

Zbig Brzezinski

The attached was returned in the President's outbox. It is forwarded to you for appropriate handling.

Rick Hutcheson

LETTER TO ROBERT D. HORMATS

THE WHITE HOUSE
WASHINGTON

	FOR STAFFING
	FOR INFORMATION
	FROM PRESIDENT'S OUTBOX
	LOG IN/TO PRESIDENT TODAY
	IMMEDIATE TURNAROUND

ACTION	FYI	
		MONDALE
		COSTANZA
		EIZENSTAT
		JORDAN
		LIPSHUTZ
		MOORE
		POWELL
		WATSON
		LANCE
		SCHULTZE

	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

Comments due to Carp/Huron within 48 hours; due to Staff Secretary next day

		ARAGON
		BOURNE
		BRZEZINSKI
		BUTLER
		CARP
		H. CARTER
		CLOUGH
		FALLOWS
		FIRST LADY
		HARDEN
		HUTCHESON
		JAGODA
		KING

		KRAFT
		LINDER
		MITCHELL
		MOE
		PETERSON
		PETTIGREW
		POSTON
		PRESS
		SCHLESINGER
		SCHNEIDERS
		STRAUSS
		VOORDE
		WARREN

THE WHITE HOUSE

WASHINGTON

September 23, 1977

ACTION

MEMORANDUM FOR: THE PRESIDENT

FROM: ZBIGNIEW BRZEZINSKI

SUBJECT: Letter of Thanks to Robert D. Hormats

Robert Hormats, who is the senior economic advisor on the NSC staff, is leaving to take a position in State as Deputy Assistant Secretary for Economics and Business Affairs. Bob has been on the staff seven of the last eight years, service spanning three Administrations. He has made a substantial contribution to our efforts in the area of international economic policy. As you know, he played an important role in organizing our participation in the London Economic Summit.

I know he would appreciate a personal word of thanks from you as he moves to his new position in State. A proposed letter is at Tab A.

RECOMMENDATION

That you sign the letter to Bob Hormats at Tab A.

THE WHITE HOUSE

WASHINGTON

To Bob Hormats

I was sad to learn that you are leaving the National Security Council staff. Zbig and I will miss you; your place will not be easy to fill. As you move to your new position in the Department of State, you can look back with pride to your many years of service on the NSC staff and to your important contribution to U.S. international economic policy. As you know, I am especially grateful to you for your invaluable assistance in organizing our participation in the London Economic Summit. The results achieved over the years in many areas of U.S. foreign policy are due in no small part to your diligent efforts. I hope that you will find your service in State as challenging and fruitful as your work here.

Best wishes for a successful career.

Sincerely,

Jimmy Carter

Mr. Robert Hormats
National Security Council
Washington, D.C. 20506

THE WHITE HOUSE
WASHINGTON

9-24-77

To Cecil Andrus

I have a personal interest in Cumberland, and hope that you will give much weight to the views of Georgia Conservancy.

Before any final decision is made, will you please let someone brief me on the Park Service plans. Thanks.

Jimmy

Hal Gulliver

Saving Cumberland Island Yet Again

They're trying to fool around with Cumberland Island again.

The "they" in this case is the National Park Service, a group that should be watched closely at all times, especially when they are planning a new park facility in a wilderness area as incredibly beautiful as Cumberland Island, that 18-mile natural wonder just off the southeast Georgia coast.

The park people tend to think about these things in the same fashion that the Army Corps of Engineers thinks about building dams. The Corps is generally in favor of anything that would give it a chance to build something, needed or not. The park service folk are hired out to run parks and to make park facilities available to as many people as possible, and there is great merit in that, but their natural tendency is to think in those terms . . . as many people as possible taking advantage of a particular park.

It would be a tragedy if the National Park Service is permitted to treat Cumberland as just another park, where people should be able to eat hot dogs and scatter litter, as many a day as possible. There are already a lot of parks for people who really don't want to be too uncomfortable while "roughing" it and whose prime concern is to be sure they can buy a candy bar and something to drink and find a restroom quickly.

Cumberland deserves to remain in its present near natural state, a glorious location of rare beauty, with beaches and sand dunes that have to be seen to be believed and areas of natural wilderness that seem probably near what they might have been a thousand years ago.

Think about it. There will be a public hearing on the matter September 24 in St. Marys, and then two public hearings in Atlanta on September 26 and 27.

At issue is the National Park Service plan to develop Cumberland substantially, a plan calling for facilities for 1,460 people per day to visit. At present, no more than 300 visitors per day have access to the island.

Now, my own belief is that is too much expansion too quickly. But, beyond that, the Georgia Conservancy challenges one major segment of the plan. The park service wants to keep only the central portion of the island in wilderness state, connecting the north and south ends of the island by a new road right through the heart of the wilderness area. This presumably would make it possible for more people to find their way to the wilderness in easier fashion. But why? Why dilute that spectacular area in such a manner?

As Hans Neuhauser, writing in the Georgia Conservancy's Newsletter put it, "Among the losses would be the unique experience of seeing Cumberland's beach disappear over the curvature of the earth without the intervening dominant hand of man."

Again, there are plenty of places and parks for people to visit if they want to be sure of roads and easy accessibility. One woman, writing to express concern about the Park Service plans for Cumberland, put it very well; she was appealing, she said, for help "to prevent the legalized rape of an Eden in Georgia."

Anyone who has visited Cumberland can value that description. The island is like an Eden, a wondrous and untouched natural spot. The National Park Service needs to be encouraged to let it remain that way.

THE WHITE HOUSE
WASHINGTON

keep copy in pres file

	FOR STAFFING
	FOR INFORMATION
X	FROM PRESIDENT'S OUTBOX
	LOG IN/TO PRESIDENT TODAY
	IMMEDIATE TURNAROUND

cc See Andrus

ACTION	FYI	
		MONDALE
		COSTANZA
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		MOORE
		POWELL
		WATSON
		LANCE
		SCHULTZE

	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

Comments due to Carp/Huron within 48 hours; due to Staff Secretary next day

		ARAGON
		BOURNE
		BRZEZINSKI
		BUTLER
		CARP
		H. CARTER
		CLOUGH
		FALLOWS
		FIRST LADY
		HARDEN
		HUTCHESON
		JAGODA
		KING

		KRAFT
		LINDER
		MITCHELL
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		PETERSON
		PETTIGREW
		POSTON
		PRESS
		SCHLESINGER
		SCHNEIDERS
		STRAUSS
		VOORDE
		WARREN

THE WHITE HOUSE
WASHINGTON

September 24, 1977

Zbig Brzezinski
Peter Bourne

The attached was returned in the President's outbox. It is forwarded to you for appropriate handling.

Rick Hutcheson

cc: Jim Fallows

RE: PAN AMERICAN HEALTH ORGANIZATION'S SPECIAL MEETING

THE WHITE HOUSE

WASHINGTON

	FOR STAFFING
	FOR INFORMATION
✓	FROM PRESIDENT'S OUTBOX
	LOG IN/TO PRESIDENT TODAY
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		PRESS
		SCHLESINGER
		SCHNEIDERS
		STRAUSS
		VOORDE
		WARREN

THE WHITE HOUSE
WASHINGTON

9/23/77

Mr. President:

Jim Fallows has edited the proposed message.

Rick

MEMORANDUM

THE PRESIDENT HAS SEEN.

THE WHITE HOUSE

WASHINGTON

ACTION

September 22, 1977

MEMORANDUM FOR: THE PRESIDENT

FROM: DAVID AARON

As you know, you designated Peter Bourne to represent you at the Pan American Health Organization's Special Meeting of the Ministers of Health. The meeting will take place September 26 here in Washington.

Peter will give the address for the U.S. Government. He would like to incorporate into his statement a special message from you to the opening session. Subject to your approval, he will deliver the attached message for you. The NSC concurs.

RECOMMENDATION

That you approve the attached message.

APPROVE ✓ DISAPPROVE ____

September 22, 1977

PRESIDENT CARTER'S MESSAGE TO THE PAN AMERICAN HEALTH ORGANIZATION

MINISTERS OF HEALTH MEETING

September 26, 1977

I reaffirm to the Ministers of Health and to the Nations you represent my belief in ~~every~~ of the human being ~~a~~ basic right to enjoy the highest attainable standard of health. No one nation can achieve this goal by itself. But by working together, we can continue to improve the standards of health and nutrition for people in all nations. My nation will do its part to support effective health and nutrition programs around the world.

I am firmly committed to the goals of the Pan American Health Organization. The distinguished accomplishments of your Organization are well known to me. On this occasion, marking your 75th anniversary, I applaud you for your past and present efforts and wish you continued future success.

JIMMY CARTER

THE WHITE HOUSE

WASHINGTON

Date: September 22, 1977

MEMORANDUM

FOR ACTION:

Jim Fallows

FOR INFORMATION:

FROM: Rick Hutcheson, Staff Secretary

SUBJECT: President Carter's message to The Pan American Health Organization. Ministers of Health Meeting September 26, 1977.

YOUR RESPONSE MUST BE DELIVERED TO THE STAFF SECRETARY BY:

TIME: Immediate Turnaround

DAY:

DATE:

ACTION REQUESTED:

__x Your comments

Other:

STAFF RESPONSE:

____ I concur. ____ No comment.

Please note other comments below:

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately. (Telephone, 7052)

THE WHITE HOUSE
WASHINGTON

✓	FOR STAFFING
	FOR INFORMATION
	FROM PRESIDENT'S OUTBOX
	LOG IN/TO PRESIDENT TODAY
✓	IMMEDIATE TURNAROUND

ACTION	FYI	
		MONDALE
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		JORDAN
		LIPSHUTZ
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	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

Comments due to Carp/Huron within 48 hours; due to Staff Secretary next day

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		H. CARTER
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✓		FALLOWS
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		HUTCHESON
		JAGODA
		KING

		KRAFT
		LINDER
		MITCHELL
		MOE
		PETERSON
		PETTIGREW
		POSTON
		PRESS
		SCHLESINGER
		SCHNEIDERS
		STRAUSS
		VOORDE
		WARREN

September 21, 1977

PRESIDENT CARTER'S MESSAGE TO THE PAN AMERICAN HEALTH ORGANIZATION

MINISTERS OF HEALTH MEETING

September 26, 1977

I reaffirm to the Ministers of Health and to the Nations you represent my deep commitment to the basic right of every human being to enjoy the highest attainable standard of health. The United States cannot alone achieve this principle. However, by working together, we can continue to improve the standards of health and nutrition for people in all nations. I want to assure you that as President of the United States I am personally committed to doing our part in supporting effective health and nutrition programs, for people everywhere.

I am firm and resolute in my commitment to the goals and principles of the Pan American Health Organization. The distinguished accomplishments of your Organization are well known to me. On this occasion, marking your 75th anniversary, I applaud you for your past and present efforts and wish you continued future success.

JIMMY CARTER

THE WHITE HOUSE

WASHINGTON

Date: September 22, 1977

MEMORANDUM

FOR ACTION: Jim Fallows

FOR INFORMATION:

FROM: Rick Hutcheson, Staff Secretary

SUBJECT: President Carter's message to The Pan American Health Organizatdon. Ministers of Health Meeting September 26, 1977.

YOUR RESPONSE MUST BE DELIVERED TO THE STAFF SECRETARY BY:

TIME: Immediate Turnaround

DAY:

DATE:

ACTION REQUESTED:

__x Your comments

Other:

STAFF RESPONSE:

____ I concur. ____ No comment.

Please note other comments below:

Revision attached.
J. Fallows 9/22/77

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required

MEMORANDUM

THE WHITE HOUSE

WASHINGTON

ACTION September 22, 1977

MEMORANDUM FOR: THE PRESIDENT

FROM: DAVID AARON

As you know, you designated Peter Bourne to represent you at the Pan American Health Organization's Special Meeting of the Ministers of Health. The meeting will take place September 26 here in Washington.

Peter will give the address for the U.S. Government. He would like to incorporate into his statement a special message from you to the opening session. Subject to your approval, he will deliver the attached message for you. The NSC concurs.

RECOMMENDATION

That you approve the attached message.

APPROVE _____ DISAPPROVE _____

September 21, 1977

PRESIDENT CARTER'S MESSAGE TO THE PAN AMERICAN HEALTH ORGANIZATION

MINISTERS OF HEALTH MEETING

September 26, 1977

I reaffirm to the Ministers of Health and to the Nations you represent my ~~deep commitment to the~~ belief in basic right ~~of~~ every human being to enjoy the highest attainable standard of health. ~~The United States cannot, alone~~ No one nation can achieve this ~~principle.~~ goal by itself. ~~However,~~ But by working together, we can continue to improve the standards of health and nutrition for people in all nations. ~~I want to assure you that as President of the United States I am personally committed to doing our part~~ My nation will, its ~~in~~ to supporting effective health and nutrition programs ~~for people everywhere~~ around the world.

I am ~~firm and resolute in~~ committed to the goals ~~and principles~~ of the Pan American Health Organization. The distinguished accomplishments of your Organization are well known to me. On this occasion, marking your 75th anniversary, I applaud you for your past and present efforts and wish you continued future success.

JIMMY CARTER

THE WHITE HOUSE
WASHINGTON

September 24, 1977

Stu Eizenstat

The attached was returned in the President's outbox on Saturday and is forwarded to you for your information and appropriate handling.

Rick Hutcheson

RE: PRELIMINARY REPORT OF PRESIDENT'S COMMISSION ON MENTAL HEALTH

To Stu
for use &
distribution
J

THE WHITE HOUSE

WASHINGTON

September 1, 1977

The President
The White House
Washington, D.C.

Dear Mr. President:

Enclosed please find the Preliminary Report of the President's Commission on Mental Health.

The Commission was established by Executive Order #11973 signed February 17, 1977. The Executive Order instructed the Commissioners to conduct such public hearings, inquiries, and studies as may be necessary to identify the mental health needs of the nation and to submit a report to the President recommending how these needs can be met, and identifying the relative priority of those needs. It called for a preliminary report to be submitted by September 1, 1977, and a final report by April 1, 1978.

In organizing our strategies and work plans for carrying out the instructions of the Executive Order, we have kept foremost in our minds the remarks you made when you signed the Executive Order. At that time you stated that you wanted to be sure that "when we end this next few months' study, we haven't reinvented the wheel, that we haven't repeated the superb work that has been done in the past, and that no group is excluded from the process." We are pleased to report that a large number of private and governmental organizations and private citizens are actively working with the Commission. The Secretary of the Department of Health, Education and Welfare has been particularly supportive by making funds and staff available to the Commission during this year.

In addition to the Commission staff of individuals experienced in the various aspects of mental health, there are 24 Task Panels composed of 233 volunteers from around the country who are to provide the Commission with overviews of special areas of concern, such as manpower/personnel needs, delivery of services, research issues and

prevention. Other Panels are concentrating on the special needs of certain population groups such as racial and ethnic minorities, the elderly and children. A complete list of these Panels is appended to this Report. These Panels have begun their work, and their initial work was particularly valuable in the preparation of this Report and will be even more so as we proceed.

In May and June, the Commission held four public hearings in different sections of the country. These hearings were designed to allow members of the public--as private citizens or representing organizations--to provide the Commission with their views of mental illness and mental health. In the hearings, the Commissioners heard testimony from approximately 200 individuals. Written testimony was submitted for the record by an additional 200. The transcript of their remarks runs to 3,000 pages.

In its first month, the Commission directed letters of inquiry to all Members of Congress and to 250 organizations and associations, both governmental and private, soliciting their views on mental health. We have also met with representatives of local, county and state governments and many have provided us with their thoughts. Finally, we have received thousands of letters from private citizens offering their assistance, suggestions and advice.

The enclosed Preliminary Report represents the results of these initial efforts. It is an interim statement of our progress and findings to date. It includes a limited number of recommendations which, in our judgment, deserve consideration at this stage because, if implemented, they offer the hope of immediate improvement in the availability of services to many of those we have identified as currently underserved.

Most of these recommendations can be implemented by executive action. In some instances, we recommend that you seek statutory changes in existing Federal laws.

The mental health problems facing the country are complex. The country's mental health system, public and private, is equally complex. There has been marked progress over the past several years, but more is necessary before we, as a Nation, can feel that we are doing our best to provide adequate help to those who need it.

In the months ahead, the Commission will do what it can to help chart a course for the future.

We wish to thank you for this opportunity and for your support. We wish to express our particular appreciation to our Honorary Chairperson, Mrs. Carter. Her dedication to improving care for those in need has not only provided forceful leadership to us, but has sparked a spirit of excitement and hope around the country. For this, all who have been touched by mental health problems and all who work in this field are grateful.

The President's Commission on Mental Health,

by _____
Thomas E. Bryant, M.D.
Chairman

Ruth Love, Vice-Chairperson
Priscilla Allen
Allan Beigel, M.D.
Jose Cabranes
John J. Conger
Thomas Conlan
Virginia Dayton
LaDonna Harris
Beverly Long
Florence Mahoney
Martha Mitchell
Mildred Mitchell-Bateman, M.D.
Harold Richman
Reymundo Rodriguez
George Tarjan, M.D.
Franklin E. Vilas, Jr., S.T.M.
Glenn E. Watts
Charles V. Willie
Julius B. Richmond, M.D., Ex Officio

PRELIMINARY REPORT TO THE PRESIDENT

FROM

THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

September 1, 1977

The February 17th Executive Order creating the President's Commission on Mental Health called for a Preliminary Report by September 1, 1977 and a Final Report by April 1, 1978.

The Preliminary Report describes the activities and progress of the Commission to date. It is a statement of initial findings and recommendations. The Report also sets forth the conceptual framework within which the Commission has worked and within which it will conduct further study in the next seven months. The Report includes a letter of transmittal. A summary of the Report follows.

SUMMARY

Scope of the Nation's Mental Health Problems

The mental health of a nation's people reflects the quality of individual lives, the strength of personal relationships, and the opportunities that exist for all people to participate fully in the national life. Thus, a complete understanding of the dimensions of mental health problems must be based on an understanding of the variety of social conditions and circumstances, as well as the biological and psychological factors, that affect the mental health of individuals.

The Commission's purpose in viewing mental health this broadly is to emphasize the variety of situations that can have a debilitating effect on emotional and psychological well-being and to recognize the additional problems and hazards faced by members of groups for whom social and environmental conditions pose an added burden. It is not to foster unrealistic expectations about what mental health services can accomplish, nor to imply that those working in the mental health field can be expected to solve all of society's ills.

Documenting the number of people who have mental health problems and the kinds of problems they have is difficult because opinions vary on how mental health and mental illness should be defined. Nevertheless, the best estimates are that 10 to 15 per cent of the population, or between 20 and 32 million Americans, need some form of mental health care at any one time. Of these 20 to 32 million people, 2 million have been or would be diagnosed as schizophrenic, and a similar number have profound depressive disorders. Patients with mental health problems occupy about 30 per cent of all hospital beds.

These numbers include people who are seen by persons working in mental health facilities. There are millions more who seek help for emotional problems elsewhere, especially from their personal physicians or from health care clinics.

Additional perspectives are obtained by considering the needs of special population groups within society who have special needs and for whom the allocation of services has not always been equitable. These include individuals requiring long-term care, emotionally disturbed children, the elderly, racial and ethnic minorities, migrant and seasonal farmworkers, and the rural population.

Scope of the Nation's Response to Mental Health Problems

During the last two decades, marked changes have occurred in the number of people receiving mental health care, the kinds of care people have received, the location of mental health services, and the cost of providing that care.

In 1975, an estimated 6.5 million persons were treated in specialized mental health settings, a 400 per cent increase over the estimated 1.7 million treated in 1955. An additional 1 million received care for mental disorders in general hospitals or nursing homes in 1975.

In 1975, approximately 75 per cent of the people receiving care were treated as outpatients, primarily in community based settings, while in 1955 approximately 75 per cent were treated as inpatients.

In 1975, the resident population of State and county mental hospitals had dropped to 191,000, a drop of 66 per cent below the 1955 population of 559,000.

In 1975, the direct cost of mental illness was approximately $17 billion, compared with the $1.7 billion spent in the late 1950s.

Professional manpower has more than tripled since 1955, with the greatest increases in the number of psychologists, social workers and other mental health professionals, such as counselors, teachers, and occupational, recreational, and arts therapists. The work of all these people continues to be augmented by the clergy, private practitioners and nurses who have always worked with a sizable portion of the population in need.

Scientific advances, government initiatives, and a variety of philosophical, social and economic factors led to this movement away from large institutions and toward community based care.

Focus of Future Work and Initial Recommendations

In the initial phase of its work, the Commission has identified a number of issues and problems that need to be addressed more fully. These can be grouped into four general categories.

I. Providing Needed Mental Health Services

Community based public and private services must be the keystone of the mental health services system. This system must include a range of diagnostic, treatment, rehabilitation, and supportive services for those who need short-term and long-term help. It must assure continuity of care and these services must be readily accessible to individuals and be coordinated with related services provided by the income support, health care, social services, and education systems. This coordinated system of care must be adequately financed and able to adapt to the needs of special population groups and to respond to the changing circumstances of individual patients.

These objectives do not describe the system in place now. They are goals against which progress can be measured over the next few years.

The Commission is especially concerned that community based services not be regarded simply as services provided outside State and county mental hospitals. There is much more to the concept than shifting the location of services. The focus must be people, not places. Accordingly the Commission plans to emphasize the wide range of services people need and the manner in which they need to receive them, the knowledge and training required to provide these services, and the planning and coordination that must exist if services are to be effective.

Meanwhile, the Commission has proposed recommendations at this time related to coordination of Federal policies supporting community services, housing for the mentally disabled, the Community Mental Health Centers Program, mental health manpower development, training for community based services, training racial and ethnic minority mental health personnel, staffing State and county mental hospitals, coordination of health and mental health planning at State level, and representation of mental health concerns in national health planning. The Commission believes these recommendations offer the hope of immediate improvement in the availability of services to many people currently underserved.

II. Financing Needed Mental Health Services

The Commission believes that national health insurance must include mental health benefits. In this context, it is studying the issues of cost and financing, financial barriers that prevent people from receiving services and the use of financial mechanisms to insure better organization of services. In addition, the Commission recommends two studies that require resources beyond those available to the Commission. The Commission also is investigating major shortcomings in existing financing and reimbursement mechanisms and recommends at this time two actions that would make Medicaid and Medicare more responsive to the needs of the mentally disabled.

III. Expanding the Base of Knowledge about Mental Illness and Mental Health

Federal dollar support of research activities in mental health has grown little since 1969, and inflation has caused an actual decrease in the buying power of these research dollars. Meanwhile, other health research and general Federal research and development funds have increased substantially. The result is a mental health research investment which is so low that it places in jeopardy the development of new knowledge and the promise of more effective means of prevention and services. This shortage of dollars has left unfunded an increasingly large number of approved, high-priority grants in the Alcohol, Drug Abuse, and Mental Health Administration. The Commission recommends percentage increase in research funds for mental health, drug abuse and alcoholism.

IV. Identifying Strategies that May Help Prevent Mental Disorder and Disability

The Commission recognizes that mental health problems cannot be solved by providing treatment alone. Efforts to prevent problems before they occur are necessary ingredients of a systematic approach to promoting mental health. At the present time there is no carefully conceived, organized national strategy for the prevention of mental illness and emotional distress and the promotion of mental health. Our initial findings, however, indicate that some specific preventive approaches are of proven merit. In the months ahead, the Commission will review these approaches and others of potential benefit and will make recommendations in its Final Report.

PRELIMINARY REPORT OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH
Synopsis of Recommendations

Introduction

There are 14 recommendations contained in the last section of the Report. These are recommendations which the Commission felt should be made at this time because:

1) They offered the hope of rapidly improving services available to many who are underserved, or
2) They relate to upcoming budgetary or legislation issues which will have to be addressed prior to the completion of the Final Report.

I. Providing Needed Mental Health Services

Recommendation #1 (see page 12 of Report)

This recommendation focuses on the need for greater coordination at the Federal Level among the many diverse agencies which are involved in providing assistance of some kind to those with mental health problems.

Recommendation #2 (see page 13 of Report)

This recommendation addresses the urgent need for more and better housing for those with mental problems who reside in their communities.

Recommendation #3 (see page 13 of Report)

This recommendation urges the President to ask for fiscal year 1979 the same level of funding for the Federal Community Mental Health Centers Program as will be available for fiscal year 1978. We ask for this so that needed services won't be diminished during the period when the Commission as well as the Administration and the Congress will be developing long range plans for the program, the authorization for which terminates on September 30, 1978. This is a budgetary recommendation, not one for statutory change.

Recommendation #4 (page 14 of Report)

This recommendation is similarly a budgetary one. It seeks the same level of funding for mental health manpower training for 1979 as for 1978 - again pending further study of long range issues.

Recommendation #5 (page 14 of Report)

This recommendation also relates to manpower training

and it asks for funding priority to be given to training certain types of manpower - that in community-based programs.

Recommendation #6. (page 15)

This addresses the need for increased training for minority workers and researchers.

Recommendation #7. (page 15)

This recommendation addresses the needs of those patients still in State and county hospitals and seeks to make more medical professional personnel available to those institutions.

Recommendations #8 and #9. (page 16)

These two recommendations address the need for more effective planning of mental health services. Number 8 addresses those problems at State level and number 9 at the Federal level.

II. Financing Needed Mental Health Services

Recommendations #10 and #11 (page 17) ask for two studies which will require resources beyond the scope of this Commission, first a study of the impact of state-mandated mental health insurance and second, an assessment of the current costs of providing different mental health services.

Recommendations #12 (page 18) and #13 (page 19) address shortcomings in Medicaid and Medicare. Number 12 seeks a way to modify certification requirements under these two programs so that psychiatric facilities are treated more like general health facilities. Number 13 seeks the establishment of a new class of Intermediate Care Facilities designed specifically to meet the conditions and needs of mental health patients.

III. Expanding the Base of Knowledge about Mental Illness and Mental Health

Recommendation #14 (page 20) seeks substantial percentage increases in the current research budgets of the NIMH, the NIDA and the NIAAA.

IV. Identifying Strategies That May Help Prevent Mental Disorder and Disability

While there are no specific recommendations under prevention, the Commission states that it supports those activities and programs which have proved beneficial and would like to see them expanded.

PRELIMINARY REPORT TO THE PRESIDENT

FROM

THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

September 1, 1977

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P R E F A C E

The Executive Order establishing the President's Commission on Mental Health calls for a Preliminary Report to the President by September 1, 1977, and a Final Report by April 1, 1978.

This Preliminary Report describes the activities and progress of the Commission to date. It is an interim statement of initial findings and recommendations.

The Commission has undertaken a number of initiatives and inquiries since its first meeting in April. While some of these inquiries have been completed, most are still in progress. This Report indicates the areas and issues the Commission believes should receive priority attention in the months ahead. These and additional issues will be addressed more fully as the Final Report is developed.

This Preliminary Report begins with a description of the scope and dimensions of America's mental health problems and of the response to those problems. This description sets forth the conceptual framework within which the Commission has worked and within which it will conduct further study as it prepares the Final Report.

SCOPE OF THE NATION'S MENTAL HEALTH PROBLEMS

> "Mental health...affects every one of us--depression, marital problems, drug and alcohol related problems, inability to cope as the result of a death or serious accident, low self-esteem, social maladjustment problems, dealing with delinquent children and so many more situations."
>
> --A citizen's letter to Mrs. Rosalynn Carter

The mental health of a nation's people reflects the quality of individual lives, the strength of personal relationships, and the opportunities that exist for all people to participate fully in the national life.

In letters the Commission has received from individuals and organizations, and in the Commission's public hearings, many expressed the belief that a complete understanding of the dimensions of mental health problems must be based upon an understanding of the variety of social conditions and circumstances, as well as the biological and psychological factors, that affect the mental health of individuals. Mental health, the Commission has been told time and time again, is much more than just the absence of mental illness.

The Commission agrees.

America's mental health problem is not limited to those individuals with disabling mental illnesses and identified psychiatric disorders. It also includes those people who suffer the effects of a variety of societal ills which directly affect their everyday lives. Vast numbers of Americans experience the alienation and fear, the depression and anger associated with unrelenting poverty and the institutionalized discrimination that occurs on the basis of race, sex, class, age, and mental and physical handicaps. The Nation must realize the terrible emotional and mental damage that poverty and discrimination cause.

In addition, the Nation's mental health problems include conditions that involve significant psychological and emotional distress but do not fit neatly into customary categories of mental disorder. These include some physical handicaps, many learning disabilities, certain types of organic brain disease, the misuse of alcohol and other drugs, and the social isolation experienced by chronically disabled persons.

The Nation must also view mental health problems in terms of the duration and intensity of care and assistance people need. There are severely distressed people who need long-term, sustaining care; people who need intensive short-term care; and people who, with only occasional or minimal assistance, can take care of themselves.

In viewing mental health this broadly, it is not the Commission's purpose to foster unrealistic expectations about what mental health services can accomplish, nor to imply that those working in the mental health field can be expected to solve all of society's ills. Neither do we intend to suggest that anyone who has a problem in life or feels troubled needs mental health care.

Rather, the purpose is to understand the variety of situations that can have a debilitating effect on emotional and psychological well-being and to recognize the additional problems and hazards faced by members of groups for whom social and environmental conditions pose an added burden.

The purpose is also to affirm that in our society individuals must have the opportunity to have their suffering alleviated insofar as possible; and to assert, emphatically, that no individual who needs assistance should feel ashamed or embarrassed to seek or receive help.

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Documenting the number of people who have mental health problems, the kinds of problems they have, how they are treated, and the associated financial costs is difficult because opinions vary on how mental health and mental illness should be defined. This difficulty is compounded because the available data often are inadequate or misleading. In part, this is attributable to the stigma associated with mental illness and emotional problems, a stigma which is still so strong that many people are reluctant to admit they need help. As a result, the prevalence of many of these handicapping conditions undoubtedly is underestimated. Nevertheless, a wide range of community surveys and treatment statistics has been used in our efforts to locate indicators of mental distress and disorder and to determine the needs of special populations.

For the past few years, the most commonly used estimate is that at any one time, 10 percent of the population needs some form of mental health care. This estimate has been used primarily for planning purposes in developing projections for manpower/personnel needs, federal, state and local budgets, and for comparisons with similar data describing other health and social problems. There is new evidence that this figure may be closer to 15 percent of the population.

An estimate based on these percentages indicates that between 20 and 32 million Americans need some kind of mental health care at any one time. The care needed is imprecisely defined and ranges from counselling to long term, sustaining care. According to the President's Committee on Mental Retardation, an additional 6 million people in the country are mentally retarded. Most of these people also require some form of care or assistance. This number is also imprecise because definitions of retardation vary.

Of the estimated 20 to 32 million people who need mental health care, 2 million people have been or would be diagnosed as schizophrenic. A similar number, or about 1 percent of the population, suffer from profound depressive disorders. More than 1 million people have organic psychoses of toxic or neurologic orgin, and other permanent disabling mental conditions from varying causes. And patients with mental health problems occupy about 30 percent of all hospital beds.

The current direct cost of providing mental health services is about $17 billion a year. The social cost, when measured in terms of lost wages and a shortened life span, is estimated to be another $20 billion. There are additional social costs related to the misuse of alcohol and other drugs and to mental retardation.

These statistics refer to people who are seen by mental health personnel in mental health facilities. There are millions more who seek help for emotional problems elsewhere, especially from their personal physicians or from health care clinics. For example, 15 percent of patients seen in general medical practice are found to have psychiatric or emotional problems. At any

given time, 25 percent of the population is under the kind of emotional stress that results in symptoms of depression or anxiety. Two anti-anxiety medications are among the most frequently prescribed drugs, and sales of one of these amounted to $245 million in 1975 alone. These data indicate that a significant portion of the dollars spent on general medical care are in reality dollars spent on mental health.

These figures help us to understand the scope and dimensions of the problem. Additional perspectives are obtained by considering the needs of special population groups within society for whom the allocation of services has not always been equitable.

Of particular concern are those people whose severe mental disabilities require long-term treatment and care. The term "deinstitutionalization" has been used to describe an approach that aims at preventing unnecessary admissions and prolonged stays in institutions, finding and developing alternatives in the community for those who do not need to be in institutions, and improving care and treatment for those who need institutional care. There is ample evidence that we are far from achieving these goals. Many mentally disabled persons still enter, reenter, or remain in public institutions when they could be treated in the community. Many of these institutions are underfunded and understaffed. In the community, many long-term patients live in group homes, foster care homes, half-way houses, room and board facilities, and "welfare" hotels. Some are excellent; others are best described as crowded, unsafe, and uncaring. Often the only community based treatment offered the long-term patient is medication.

According to the best recent estimates, 8.1 million of the 54 million children and youth of school age, or 15 percent of that population, need help for psychological disorders. Varying estimates show that anywhere from 1 to 2 million children have specific learning disabilities. Special teaching techniques have been developed for many of these disabilities, but they are not widely available. One of every 3,000 children has an autistic disorder. There are 200,000 cases of child abuse reported every year, and surveys indicate the total number may be at least ten times greater. Adolescents show an alarming increase in suicide, depression, and alcohol and drug misuse.

The incidence of mental health problems is higher among people sixty-five and older than in other age groups. The elderly often are subject to multiple stresses such as mandatory retirement, a dramatic drop in income, a sense of uselessness, social isolation, grief over the loss of loved ones, and a fear of illness and death. The elderly account for 25 percent of all reported suicides though they represent only 11 percent of the population. Estimates indicate that 20 to 30 percent of all people labelled as "senile" have conditions that are either preventable or reversible if detected and treated early.

Another mental health related problem which pervades society is the misuse of alcohol. Recent surveys estimate that 10 million people have a significant and recent alcohol-related problem and that another 10 million have experienced an alcohol-related problem of some sort during their lifetime. At present, about 1 million people are receiving help for their alcoholism. The use of alcohol and states of depression are closely related, as are the use of alcohol and violent behavior.

Similarly, the non-therapeutic use of psychoactive drugs other than alcohol can have profound mental health implications for individuals, their families and communities. It is estimated that more than 500,000 Americans are dependent on heroin. This is in addition to the millions of Americans who experiment with and use a wide variety of mind and mood altering drugs on a frequent basis, often with harmful results to themselves and society.

At the Commission's public hearings, the social and economic conditions in which millions of minority persons live and which make them so vulnerable to psychological and emotional distress were vividly described by representatives of racial and ethnic minorities. These problems--malnutrition, inadequate housing, poor schools, unemployment, insufficient and inappropriate health and social services--are common to all minorities. However, each racial and ethnic minority group also has problems that are unique to it and which increase its vulnerability to mental and emotional distress.

Migrant and seasonal farmworkers and their families also live under conditions of terrible economic and social stress. Their emotional and mental problems are compounded by the almost total lack of mental health and other services available to them.

America's rural population is often susceptible to stresses associated with geographic isolation, the disruption of traditional ways of life, and poverty. The prevalence of severe emotional disorders in rural areas generally parallels that of urban areas, but people who live in rural areas have fewer mental health facilities and trained manpower to assist them.

The letter quoted at the beginning of this Report is a reminder that mental health affects us all. And as we expand our perspective, we begin to understand that the causes of mental health problems are as varied as their manifestations. Some are physical. Some are emotional. Some are rooted in social and environmental conditions. Most are a complex combination of these and other factors, some of which are unknown.

Their common bond, however, is that they exert or have the potential to exert a harmful effect on the ability of individuals to function in society, to develop a sense of their own worth, and to maintain a strong and purposeful image of themselves.

SCOPE OF THE NATION'S RESPONSE TO MENTAL HEALTH PROBLEMS

The last two decades have been a period of ferment, of broader perspectives and new ideas about mental health. There has been greater public interest in the psychological aspects of human behavior and increased awareness of the close relationship between individual behavior and the social environment.

Within the mental health field itself, new theories and models of thinking about mental health have been developed. Traditional psychiatric concepts have been under intense scrutiny. Some leaders in the field assert that individual mental disorders signal pathological relationhips in families, at the workplace, and in society. Others advocate using behavioral rather than traditional psychiatric concepts to understand and treat disordered behavior. Still others are not as concerned about these issues, but see certain types of therapy and involuntary treatment as unwarranted infringements on personal liberties.

As our understanding of the relationships between physical and mental health and of the influence of social and environmental factors on both increases, our concepts of mental illness and mental health will continue to be refined.

These past two decades have also seen a movement away from large institutions and toward community based care. Marked changes have occurred in the number of people receiving mental health care, the kinds of care people have received, the location of mental health services, and the cost of providing that care.

In 1955 an estimated 1.7 million people were treated in specialized mental health settings. By 1975 this number had increased to 6.5 million, with an additional 1 million receiving care for mental disorders in general hospitals or nursing homes.

In 1955 approximately 75 percent of people receiving care were treated as inpatients, primarily in large institutions. By 1975 approximately 75 percent were being seen as outpatients, primarily in community based settings.

Between 1955 and 1975 the resident population of State and county hospitals dropped from more than 550,000 to less than 200,000.

While in 1975 1.5 million Americans received care as inpatients in State and county hospitals, private mental hospitals, general hospitals, Veterans Administration hospitals, and in Community Mental Health Centers, a significant reduction occurred in the average length of stay for hospitalized patients. Between 1971 and 1975 the average length of stay in State and county hospitals dropped from 44 days to 26 days.

In the late 1950s, the direct cost of mental illness was estimated to be $1.7 billion a year. In 1975 the direct cost of mental illness was approximately $17 billion.

During this period there have also been many changes in the number and types of personnel providing specialized mental health services. Professional manpower has more than tripled since 1955. There are presently over 350,000 individuals involved in direct patient care. As treatment has shifted to outpatient settings, the greatest increases in the staffs of mental health facilities have been in the number of psychologists, social workers, and other mental health professionals, such as counselors, teachers, and occupational, recreational, and arts therapists.

With increases in Federally supported social service programs, the number of social workers and counselors helping people resolve mental health related problems in settings ranging from schools to social welfare agencies has also grown. The work of all these people continues to be augmented by the clergy, private practitioners, and nurses, who have always worked with a sizable portion of the population in need.

Scientific advances, government initiatives, and a variety of philosophical, social, and economic factors led to these changes.

* Basic research following World War II contributed to the development of a broader and more effective range of psychological and chemotherapeutic methods of treatment.

* The 1961 Final Report of the Congressionally authorized Joint Commission on Mental Illness and Health provided the conceptual framework for the shift toward community based care.

* The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 and its subsequent amendments have been important legislative vehicles in the development of community based services. The Community Mental Health Centers whose initial funding was provided under that Act will soon be in operation in service areas that include 43 percent of the Nation's population. The centers account for 28 percent of services provided in mental health facilities.

* Federal initiatives in health care financing and expanded social services have made available financial assistance that has made it possible to provide more care in local communities. In some States more people could afford to live outside institutions because of increased benefits under programs like Aid to the Permanently and Totally Disabled, and more recently the Supplemental Security Income Program (Title XVI of the Social Security Act). Medicare and Medicaid funds have been used to support many elderly and retarded patients in nursing homes and other local facilities.

* During the past decade the civil rights and consumer movements have provided the impetus for reform of State law pertaining to commitment procedures and policies. Several court decisions have also emphasized patients' rights and have set minimum standards for patient care. These legislative and court actions have accelerated the return to their communities of thousands of patients from State and county hospitals.

Taken together, these developments have ended the era of care in large State and county institutions and ushered in an era of providing mental health services in the community--an era, however, that is not without problems of its own.

FOCUS OF FUTURE WORK AND INITIAL RECOMMENDATIONS

In the initial phase of its work, the Commission has identified a number of issues and problems that need to be addressed more fully. These can be grouped into four general categories:

I. Providing needed mental health services.

II. Financing needed mental health services.

III. Expanding the base of knowledge about mental illness and mental health.

IV. Identifying strategies that may help prevent mental disorder and disability.

The following discussion of these issues includes the Commission's initial recommendations and the reasons for them.

I. Providing Needed Mental Health Services

Community based public and private services must be the keystone of the mental health services system. This system must include a range of diagnostic, treatment, rehabilitation, and supportive services for those who need short-term and long-term help. It must assure continuity of care and it must be readily accessible to the people who need to be served. Mental health services must be coordinated with related services provided by the income support, health care, social service, and education systems so that each person receives all the care and support he or she needs. This coordinated system of care must be adequately financed, and it must be able to adapt to the needs of special population groups and to respond to the changing circumstances of individual patients. People who need help must be able to get help when they need it and at a reasonable cost.

These objectives should guide the development of the system we hope to have in place in the future; they do not describe the system in place now. In this sense, they are goals against which progress can be measured over the next few years.

The Commission cannot provide a single blueprint for all communities to use in developing community based mental health services, because each community must have a system that responds to its own needs.

The Commission can help the development of community based systems of care, however, by identifying the components and features of well-developed, community based services and by examining the issues involved in establishing such services. In pointing out ways in which existing services contribute or fail to contribute to the long-range goals, the Commission will pay particular attention to those for whom inadequate services now exist.

The Commission is especially concerned that community based services not be regarded simply as services provided outside State and county mental hospitals. There is much more to the concept than shifting the location of services. The focus must be people, not places. Accordingly, the Commission plans to emphasize the wide range of services people need and the manner in which they need to receive them, the knowledge and training required to provide these services, and the planning and coordination that must exist if services are to be effective.

The problem of planning and coordinating is evident at the Federal level. The Comptroller General reported earlier this year that 11 different Federal agencies and departments administer 135 programs that have an impact on people with mental health or emotional problems. Many of these programs frequently serve the same individuals but fail to serve common or coordinated objectives. Too often the staffs of those Federal agencies that do not have mental health as their primary focus overlook the benefits their programs can offer the mentally disabled. To achieve better coordination and to define the responsibility of different Federal agencies to improve and increase service to the mentally disabled, the Commission recommends that the President:

1. Establish an interagency group within the Federal Government to coordinate policies and programs affecting the development of community based care for the mentally disabled so that they better serve the long-term objectives set forth by this Commission.

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Urgent concern is being voiced about the special needs of the large number of people who suffer long-term mental disabilities and who need supportive care in their communities. They include some persons who in the past would have been sent to State and county institutions, and others who have returned to their communities after spending years in such institutions. Services for both groups often are inadequate or non-existent. Not only is continuity of care lacking, little attention is given to meeting such basic needs as adequate food, clothing, and shelter. Unless such needs are met, it may not be possible to keep these people out of hospitals.

In the coming months, the Commission will systematically examine ways to assist these individuals. Our initial inquiries have been directed toward the need for adequate and affordable housing. Section 8 of the United States Housing Act of 1937, as amended by Section 201(a) of the Housing and Community Development Act of 1974, makes it possible for many low-income persons, including mentally disabled persons who have low incomes, to obtain adequate housing. Section 106 of the 1974 Act provides grants to State and local governments for community development programs, including projects which make it easier for handicapped persons to live in their communities. These programs can assist many mentally disabled individuals--particularly by supportive group living arrangements that are both less costly and more therapeutic. The Commission supports the Department of Housing and Urban Development's recently stated goal of making 5 percent of Section 8 funds available for assisted housing for the handicapped, and its encouragement of local communities to spend a greater portion of their community development block grant funds to assist the mentally handicapped; but the need is much greater. Accordingly, the Commission recommends that the President direct:

2. The Department of Housing and Urban Development to: (a) encourage States and localities to allocate additional Section 106 funds to develop more group care facilities, and (b) make additional Section 8 rental assistance funds available to mentally disabled persons living in group homes.

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The Community Mental Health Centers Program is an important Federally assisted activity. Since its beginning, Federal grants for these centers have totalled about $1.5 billion. The legislation authorizing these grants terminates on September 30, 1978, and the Congress will soon begin considering the future of this program. The Commission is examining the program and intends to complete its work in the next few months. Our initial findings indicate that the centers, though a good method of providing community based services, are not the only method of providing these services. Individual centers have made substantial contributions to the communities they serve, but important questions have been raised about the concept and implementation of the program. Pending completion of its study, and out of a strong concern that nothing happen that will undermine previous accomplishments and cause a reduction or loss of worthwhile services, the Commission recommends that the President request that:

3. Funds for the Community Mental Health Centers Program in fiscal year 1979 be at least equal to funds for fiscal year 1978.

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It is inappropriate to discuss community based services without also focusing on the people who will provide those services. As noted earlier in this Report, there have been substantial increases in the number and types of mental health personnel during the past two decades, but many problems still require attention. For example, there is a geographic maldistribution of professionals. The professions include too few minority members. Mental health personnel in training often do not have sufficient opportunity to learn and practice their skills in community based settings. Efficient utilization of all mental health manpower is hindered by reimbursement mechanisms which pay only for the services of certain professionals. Concerns about reimbursement, coupled with uncertainties regarding definitions of roles and responsibilities, create tensions among professions and between professionals and other mental health workers that ultimately work to the disadvantage of the patient.

The effective implementation of mental health manpower development programs has been disrupted in recent years by abrupt changes in Federal policies and the controversies these changes have generated. Since manpower development is a long-term process, these disruptions have been very costly. The Commission has under way an assessment of manpower/personnel needs and issues. Pending completion of this assessment, and to avoid further disruption, the Commission recommends that the President request that:

4. Funds for mental health manpower training in fiscal year 1979 be at least equal to funds for fiscal year 1978.

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Our initial inquiries show that increased effort must be made to recruit and prepare individuals to provide community services, including clinical and preventive services appropriate to different values and life-styles. The Commission recommends that the President direct:

5. The Department of Health, Education, and Welfare to give funding priority to (a) training professionals and others for work in community programs, (b) training State and county hospital staff for work in community services, and (c) mental health training for primary health care practitioners.

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Good mental health care requires continuing sensitivity to cultural differences in the American population. If those who provide mental health services do not speak their language and are not sensitive to their culture, minority Americans will receive inadequate services, or may go without treatment. Increasing the number of minority people who provide and direct mental health services, and raising the cultural sensitivity of other staff, are necessary steps toward solving these problems. Therefore, the Commission recommends that the President also direct:

6. The Department of Health, Education, and Welfare to give further priority to training (a) minority mental health workers, (b) researchers from minority groups, and (c) persons serving bicultural and bilingual groups.

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The emphasis on community based care must not lead to the neglect of people in State and county mental hospitals. Many chronically disabled mental patients continue to require long-term or periodic care in these institutions. A variety of staff is required to meet their needs. There are shortages in many areas, and the prospective reduction in the supply of foreign medical graduates is likely in the near future to compromise further the quality of care these patients receive by decreasing the number of physicians available to provide care.

Under Section 332 of the Public Health Service Act which authorizes the National Health Services Corps, new criteria currently are being developed which will permit the designation of State and county mental hospitals as "health manpower shortage areas." This will make it possible for National Health Services Corps personnel to fulfill their service obligations in these institutions. Therefore, the Commission recommends that the President direct:

7. The Secretary of Health, Education, and Welfare to designate as health manpower shortage areas all State and county hospitals which are inadequately staffed with physicians.

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Two Federal laws are concerned with planning for mental health services. These are the National Health Planning and Resources Development Act (P.L. 93-641) and the Community Mental Health Centers Act (P.L. 94-63, as amended). The experience to date has indicated that these different

planning efforts have resulted in a lack of coordination in many communities and States and direct conflicts in some. To ensure that the planning under these laws is consistent, the Commission recommends that the President seek changes in Federal law which would require that:

8. Plans of Health Systems Agencies and State Health Planning and Development Agencies under Public Law 93-641 be consistent with State Mental Health Plans under Public Law 94-63.

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To give stronger voice to mental health issues in the development of the health planning program at the national level, the Commission recommends that the President seek a second change in Federal law which would require that:

9. The National Council on Health Planning and Development include at least two representatives from the mental health field.

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II. Financing Needed Mental Health Services

This Commission believes mental health benefits must be included in a national health insurance program. Current deliberations over national health insurance present this Commission with a special opportunity and responsibility to study the issues of costs and financing; to examine the ways in which financial barriers prevent people from receiving services; and to determine how financing mechanisms can be used to help develop a more organized and effective network of mental health services. The Commission has begun its study of these issues and is working closely with those charged with the responsibility of developing national health insurance proposals.

Public and private insurance plans provide many more benefits for general medical care than for mental health care. Furthermore, most plans which have mental health benefits offer inadequate coverage. A recent survey on group health insurance coverage indicated that benefits for outpatient visits are usually limited to $500 per year and that patients themselves usually must pay one-half of the bill.

A number of States have begun to require that a specified level of mental health benefits be included in new private health insurance policies. We know very little about how these requirements affect State hospitals, Community Mental Health Centers, and other mental health care providers. It is possible that expanded mental health benefits may enable even more patients to be treated outside State hospitals. We do not know enough about how providing mental health benefits will affect the utilization of general health services. These subjects have important implications for national health insurance and warrant immediate study. This study, however, requires resources beyond those available to this Commission. Therefore, the Commission recommends that the President direct:

10. The Secretary of Health, Education, and Welfare to promptly undertake an analysis of the impact of State programs which mandate mental health benefits under private health insurance.

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In order to make the most accurate projection about the cost of including mental health benefits in a national health insurance program, we need to know more about the current cost of providing specific mental health services in existing settings. This also is a subject that deserves immediate attention but requires resources beyond those available to this Commission. Accordingly, the Commission recommends that the President direct:

11. The Secretary of Health, Education, and Welfare to undertake an assessment of the current costs of providing specific mental health services in different settings and organizations.

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The Commission also plans to study major shortcomings in existing financing and reimbursement mechanisms such as Medicaid and Medicare.

One important problem is that Federal financing mechanisms often have lagged behind changes in mental health services. The Community Mental Health Centers Program implies a strong Federal commitment to outpatient mental health care and the advantage of providing service in the least restrictive, most appropriate setting. Medicare and Medicaid programs provide limited mental health benefits, and these are biased toward inpatient care.

Between now and April 1, 1978, the Commission will examine how existing financing mechanisms could be revised to make mental health benefits more comprehensive and more appropriate. Constraints which make it difficult to provide a full range of mental health and social services and to achieve continuity of care will be examined. Recommendations for statutory changes will be considered, such as amendments to the Social Security Act that would broaden the definition of health care "provider" to include Community Mental Health Centers and other organized systems of mental health care.

The Commission already has identified two changes in Medicare and Medicaid that can save money and improve services but which do not require statutory change for implementation. One concerns psychiatric inpatient facilities; the other, intermediate care facilities.

Current requirements relating to the eligibility of these facilities for reimbursement are based primarily on the needs of people with serious physical handicaps. Many of these standards are not necessary for mental patients and they increase cost. More flexible rules and standards which better meet the special needs of the mentally disabled can help ensure that Federal financing programs respond to special local needs and changing conditions.

Requirements relating to psychiatric inpatient services should be modified. Specifically, alternative standards and provisions for specific waivers should be developed with respect to the physical plant, construction, record-keeping, staffing patterns, and program requirements. The Commission recommends that the President direct:

12. The Secretary of Health, Education, and Welfare, in cooperation with a task force of local practitioners and hospital administrators, to modify certification requirements under Medicare and Medicaid for State mental hospitals and other psychiatric inpatient services to assure that they are not unduly restrictive.

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Similarly, some Medicaid requirements for Intermediate Care Facilities are irrelevant or excessive for mental health patients. They not only increase construction costs in many cases, they also encourage the establishment of larger institutions rather than the smaller home-like facilities more desirable for providing support in the community. At the same time, they say nothing of the special services needed by many mental health patients. Therefore, the Commission recommends that the

President direct:

13. The Secretary of Health, Education, and Welfare to establish in Medicaid a class of Intermediate Care Facilities that are designed specifically to meet the conditions and needs of mental patients.

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III. Expanding The Base Of Knowledge About Mental Illness and Mental Health

Expanding our understanding of the functioning of the mind, the causes of mental and emotional illness, and the efficacy of various treatments is crucial to future progress in mental health.

Biological, psychological, and epidemiological research since World War II, much of it Federally funded, has furthered our understanding of the causes of mental illness. Federal dollars have also supported social science research which has demonstrated the impact of situational stress and environmental conditions on emotional well-being. Behavioral and clinical research has contributed to important advances in the treatment of depression, schizophrenia, and behavior and learning disorders.

Federal dollar support of research activities in mental health has grown little since 1969, and inflation has caused an actual decrease in the buying power of these research dollars. Meanwhile, other health research and general Federal research and development funds have increased substantially. The result is a mental health research investment which is so low that it places in jeopardy the development of new knowledge and the promise of more effective means of prevention and services. This shortage of dollars has left unfunded an increasingly large number of approved, high-priority grants in the Alcohol, Drug Abuse and Mental Health Administration.

Despite this loss of momentum, major opportunities for expanding our base of knowledge still exist.

In mental health, new discoveries regarding the role of neurotransmitters and chemical imbalance in the brain hold great promise for the treatment of schizophrenia and depression. More extensive studies of psychological, social, and biological factors affecting the mental health of certain populations, such as children and the elderly, offer hope for prevention and better treatment of certain disorders.

In drug abuse research, progress in identifying receptors in the brain can lead to a more accurate understanding of the addictive process and to the development of more effective treatment techniques. Fuller understanding of the influence of social and situational stress on drug use in various age groups and in special populations will make it possible to plan more effective treatments.

In alcohol research, further investigations of possible biochemical and psychological factors related to dependence on alcohol is necessary. There must also be prompt follow-up studies of recent findings that a predisposition to alcohol may be inherited, and that heavy consumption of alcohol by women during pregnancy increases the risk of mental and physical abnormalities to the fetus.

In these and other areas, intensified clinical research on treatment efficacy, the development of new models of care, and evaluative research on service delivery can improve the use of scarce resources, making them more available to all in need, but especially to those currently underserved.

The Commission believes that the knowledge to be gained from such studies would greatly advance the understanding of mental illness and mental health and would significantly increase the ability to provide assistance to those in need. Accordingly, the Commission recommends that the President request that:

14. The research budget of the Alcohol, Drug Abuse, and Mental Health Administration for fiscal year 1979 include (a) increases in the $117 million research budget of the National Institute of Mental Health in the range of 20 percent, (b) increases in the $16 million research budget of the National Institute on Alcohol Abuse and Alcoholism in the range of 30 percent, and (c) increases in the $34 million research budget of the National Institute on Drug Abuse in the range of 35 percent.

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The Commission intends to study how mental health research is planned and organized, how priorities for funding evolve, and how research findings are disseminated to people working in the field. The Commission will concern itself with research that is specifically directed toward improving the organization and delivery of services. Research manpower needs also will be addressed.

Based on its experience, the Commission is particularly concerned about the need for better, more reliable data about the location and incidence of mental health problems and the utilization of mental health services. Without reliable data, realistic planning is impossible. The Commission will thus pay close attention to the question of how to promote, fund, and undertake mental health services and epidemiological research.

The review will include not only the research programs of the Alcohol, Drug Abuse, and Mental Health Administration, but also related work at the National Institute for Child Health and Human Development, the National Institute on Aging, the Administration on Aging, and other agencies which, though not identified as "mental health" agencies, conduct research that has an important bearing on mental health services and the prevention of mental illness and disability.

IV. Identifying Strategies That May Help Prevent Mental Disorder and Disability

The Commission recognizes that mental health problems cannot be solved by providing treatment alone. Efforts to prevent problems before they occur are necessary ingredients of a systematic approach to promoting mental health. As evidence accumulates that specific preventive measures reduce the need for later treatment, there is growing acknowledgement of the value of prevention.

At the present time there is no carefully conceived, organized national strategy for the prevention of mental illness and emotional distress and the promotion of mental health. Indeed, there is disagreement over how such a strategy should be developed, of what it should consist, and who should carry it out--all important issues the Commission will address in the coming months.

Our initial findings, however, indicate that some specific preventive approaches are of proven merit. For example, the value of comprehensive prenatal care and adequate nutrition in reducing the occurrence of mental disorder is quite clear.

Similarly, there is persuasive evidence that early childhood intervention, developmental day care, and pre-school programs such as Head Start provide measurable benefits to children and significantly reduce the likelihood of the school failure so frequently associated with emotional disorders in children and adolescents.

There are innovative programs around the country which are effectively teaching individuals--children and adults--how to strengthen their coping and problem-solving abilities. Some of these programs are in schools, some are in correctional institutions. Others are operated by churches and self-help groups.

While the Commission supports those activities and programs which have proved beneficial in preventing mental and emotional disorders, and wishes to see such programs expanded, it has not had sufficient opportunity to review the field thoroughly and to establish priorities among them.

In the months ahead, the Commission will review these approaches and others of potential benefit and will make recommendations in its Final Report.

CONCLUSION

In this Report, the Commission has set forth its initial findings and recommendations. We have indicated how we have proceded up to now and how we plan to proceed in the months ahead as we prepare our Final Report. In closing this beginning phase of our work, we wish to emphasize two important points.

The first is that the time has come for mental health care to become part of a broader effort to deal with human needs. Although mental health services often focus on a particular aspect of a person's problems, our fundamental concern is for the whole person. The Commission believes it is important to restate its conviction that mental health services must not be isolated from other important health, social and educational services.

The second relates to the stigma surrounding mental and emotional illness. During the past few months, we have developed an increased sensitivity to the enormous need for greater public understanding of mental and emotional problems and of the value and efficacy of modern methods of treatment. The stigma of mental illness, however, is so pervasive in our society that many who need help do not seek it. The misunderstanding and fear surrounding mental and emotional problems are so great that there is insufficient public support for needed services and further research.

In many ways, this is surprising. Almost all Americans are touched by these problems, either themselves or in their families or among their neighbors and friends. Nevertheless, this stigma and the fears exists, and they are deeply ingrained in our society. Unless we deal constructively with these problems, future progress will be slowed and those currently underserved are likely to remain largely underserved.

APPENDIX

The Commission wishes to express its appreciation to the 233 individuals from the private sector who are volunteering their time and contributing their expertise to the Commission's work by serving on 24 Task Panels. Their assistance is invaluable. The subject areas in which these individuals are working are as follows:

Mental Health - Problems, Scope and Boundaries

Service Delivery

- Organization and Structure
- Community Mental Health Centers Assessment
- Planning and Review
- Access and Barriers

Deinstitutionalization, Rehabilitation, Long-Term Care

Manpower and Personnel

Cost and Financing of Mental Health

Research Issues

Prevention

Legal and Ethical Issues

Mental Health and the Family

- Infant and Child
- Adolescents
- Adult Years
- Elderly

Special Populations - Minorities, Women and Physically Handicapped

Rural Mental Health

Community Support Systems

The Role of Arts in Mental Health

Liaison Task Panel on Alcohol-Related Problems

Liaison Task Panel on Drug-Related Problems

Liaison Task Panel on Mental Retardation

THE WHITE HOUSE
WASHINGTON

September 24, 1977

Stu Eizenstat
Charles Schultze

The attached was returned in the President's outbox. It is forwarded to you for your information.

Rick Hutcheson

RE: LETTER TO SENATOR MOYNIHAN
"THE FEDERAL GOVERNMENT
AND THE ECONOMY OF NEW YORK
STATE

cc: Frank Moore

THE WHITE HOUSE

WASHINGTON

	FOR STAFFING
	FOR INFORMATION
	FROM PRESIDENT'S OUTBOX
	LOG IN/TO PRESIDENT TODAY
	IMMEDIATE TURNAROUND

ACTION	FYI	
		MONDALE
		COSTANZA
/		EIZENSTAT
		JORDAN
		LIPSHUTZ
		MOORE
		POWELL
		WATSON
		LANCE
X		SCHULTZE

	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

Comments due to Carp/Huron within 48 hours; due to Staff Secretary next day

		ARAGON
		BOURNE
		BRZEZINSKI
		BUTLER
		CARP
		H. CARTER
		CLOUGH
		FALLOWS
		FIRST LADY
		HARDEN
		HUTCHESON
		JAGODA
		KING

		KRAFT
		LINDER
		MITCHELL
		MOE
		PETERSON
		PETTIGREW
		POSTON
		PRESS
		SCHLESINGER
		SCHNEIDERS
		STRAUSS
		VOORDE
		WARREN

THE PRESIDENT HAS SEEN.

THE WHITE HOUSE

WASHINGTON

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September 22, 1977

MEMORANDUM FOR THE PRESIDENT

FROM: CHARLES SCHULTZE CLS
STU EIZENSTAT Stu

SUBJECT: Response to Senator Moynihan's Statement on "The Federal Government and the Economy of New York State"

Attached is a copy of our letter to Senator Moynihan.

THE CHAIRMAN OF THE
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON

September 22, 1977

The Honorable Daniel P. Moynihan
Member of the Senate
1109 Dirksen Building
Washington, D. C. 20510

Dear Senator Moynihan:

At the President's request, we have reviewed your statement on "The Federal Government and the Economy of New York State." Your report identifies a number of significant issues that have received inadequate attention at the Federal level in the past. The President already has written to you to express this Administration's commitment to give close attention to those issues in the months and years ahead. We would like to comment in somewhat greater detail on the matters discussed in your statement.

Your report cites four areas in which Federal policies impact New York State's economy:

-- Federal tax revenues collected from New York exceed Federal outlays in the State. According to the report, New York State paid $36 billion in Federal taxes in 1976 and received $26 billion in expenditures (excluding interest on the Federal debt). In particular, you expressed the concern that New York "loses out" in spending for defense, highways, inland waterways, and electrical generating facilities.

-- New York State is victimized by faulty allocation formulae in Federal grant programs that emphasize average state incomes without regard to income distribution, urban congestion, or cost differentials among regions.

-- Free trade policies have contributed to the decline of New York's garment industry, a mainstay of the local economy.

-- Environmental restrictions inhibit new investment in New York City. In particular, standards set under the Clean Air Act discourage construction of power plants and factories, as well as requiring reduction of automobile traffic in the City.

Although we take issue with some technical details of your analysis, which we will discuss below, we agree in certain respects with your assessment. This Administration is, and should be, committed to a number of steps that are responsive to the problems that you have pointed out. Taking your concerns one at a time:

> The "Balance of Payments" of individual states with the Federal Government is not an appropriate measure of the Federal impact on individual states, but there is little doubt that the Government today pays too little attention to the economic impact of its policies on particular regions.

The principal reason for New York's "deficit" is that its Federal tax payments are high, not that Federal expenditures in New York State are low. Tax payments are high because New York is a high income state -- fifth highest per capita income in the Nation -- and our tax system is progressive. In addition, corporations headquartered in New York pay taxes on profits earned in other states. New York is not critically disadvantaged in receipt of Federal expenditures. Only 18 states receive higher Federal outlays per capita than New York. New York State does fall short in per capita measures for those expenditure categories -- natural resources, highways, water projects -- for which it may have a lesser need per capita than other states because of its geographic and demographic characteristics.

We do not believe that Federal purchases of goods and services -- like missiles, or automobiles, or supplies -- should be ordered, even approximately, on the basis of regional calculations of tax payments vs. purchases. One could, in theory, draw up a New York State balance sheet for consumer purchases of various categories of goods (New York consumer payments for the good versus inflows of orders to New York factories for producing the good). This would show very substantial imbalances for a very wide range of goods. And yet it would not mean very much. It is quite likely that the aggregate balance has only a small effect on the State's economy because of interstate trade flows. Purchases by residents of one state generate demands for products made all over the country and the products made in one state may be sold around the world.

We do agree that the Federal Government needs more systematic information on the overall impact of all of its programs, collectively, on regional economies. The President's Reorganization Project has begun a study of the Government's "Economic Analysis and Policy Machinery." That study will review the Government's ability to conduct regional analysis

and to integrate this analysis into the decision-making process. In addition, one Task Force working with the Urban and Regional Policy Group is beginning a systematic review of programs that affect the finances of state and local governments. This project will establish an on-going process for review of the financial positions of state and local governments and of ways in which the Federal Government can improve them. Another Task Force is developing proposals directed toward urban economic development; this policy issue has a very high priority.

> While only three states receive more per capita grants-in-aid than New York, and while the Temporary Commission noted that New York City generally receives a fair proportion of block grant and general revenue funds, we also agree that many distributional formulae are faulty, in some cases to the detriment of New York.

New York State is clearly disadvantaged by particular distribution formulae which put too much weight on average income, since this single statistic does not adequately reflect New York's very unequal distribution of income around the mean. Formulae certainly should take account, in a sensible way, of such factors as poverty, congestion, regional costs and other specific considerations appropriate to particular programs. It is impossible, however, to estimate now the net consequences for a particular state of rationalizing a large number of formulae.

It will be a difficult process to correct all the faulty formulae that may be imbedded in the large number of current Federal programs. The President is committed, however, to reviewing, simplifying, and consolidating programs. He has already specifically identified the fields of human services and community development as high priorities for the Reorganization Project. This provides a very useful opportunity to develop new and better formulae in the context of weeding out duplication, and possibly contradiction, among existing programs.

Moreover, the Administration has recommended new distribution formulae for public works funds and for funds allocated under the Community Development Block Grant program, which will be beneficial to New York State.

> Imports can adversely affect particular regions and industries - including clothing as an important example - but another important factor in the decline of the New York garment industry is the movement of that industry to other locations in the country.

The New York garment industry has suffered from competition from two directions: the rapid growth of the industry in other parts of the country and foreign competition. The importance of the first factor is demonstrated by the fact that New York City's share of total domestic apparel production has been cut in half in the past 20 years. In addition, the growth of apparel imports has undoubtedly also had an adverse effect on employment in this industry.

There are compelling national reasons for trying to keep trade barriers down. This policy is advantageous for consumers, maintains competitive pressures which help combat inflation and forestalls retaliatory responses by our trading partners. These advantages should not, however, be bought at undue cost to workers in particular industries. We have worked closely with leaders of the garment industry and unions in New York to help insure the protection of such workers.

This Administration is making efforts (under the umbrella of the Multi-Fiber Arrangement) to negotiate bilateral agreements that will contain the growth of imports in those apparel items that are most seriously impacted by trade. The bilateral agreement tentatively worked out with Hong Kong should be very beneficial to the New York garment industry. Furthermore, proposals for a major overall of the Government's trade adjustment assistance program have received extensive interagency review and a proposal for administrative and legislative action will be announced shortly.

There also is a more general employment problem facing New York State. Even after allowing for the influence of recession, it appears that nonfarm employment in New York has trended down since 1969. In recent years, employment generally has grown more slowly in the industrialized states of the Northeastern quadrant than elsewhere, owing to population movements and the decline in production of goods relative to services. New York, however, is the only state in which a secular decline in employment has been observed. The Federal Government is and must be concerned with such a development.

We are aware of the necessity to balance the benefits of a better environment against the benefits of economic growth, but the effects of poor environment on the residential location decisions of affluent citizens must also be considered.

We are committed to the enforcement of strong environmental standards. Arbitrary enforcement may inhibit industrial growth and, in the absence of other measures affecting transportation facilities, adversely affect congested commercial areas. The financial plight of central cities will be made worse, however, if the environment is permitted to deteriorate and this leads the most affluent (and hence, most mobile) citizens to move out of the city.

Regulatory reform is a high priority of this Administration. We are eager to see a number of steps taken to make regulations more flexible and adaptable to the particular costs and benefits in particular regions and industries. The recent compromise reached by New York City concerning on-street parking in Manhattan is indicative of flexibility on the part of EPA. EPA is working with others in the Administration to devise ways to maintain and strengthen economic incentives for environmental protection while avoiding some of the problems that enforcement of regulations may impose on congested or heavily industrialized areas.

We intend to continue to monitor carefully the regional impact of economic policies, regulatory decisions, and Government programs in order to balance carefully national and regional needs. We appreciate this opportunity to review these issues with you.

Sincerely yours,

Charles L. Schultze

Stu Eizenstat

Stuart Eizenstat
Assistant to the President
for Domestic Affairs and Policy